Form - 301

alternative Service Concepts, L.L.C.

A PROGRESSIVE RISK SOLUTIONS FIRM

IOD OUT-OF-POCKET EXPENSE REIMBURSEMENT FORM

Employee Name: _____

Department: _____

Date of Injury: _____

Body Part Injured: _____

Please complete the top portion, read and sign the certification and attach any receipt(s) that you have for reimbursement.

I hereby certify that I have paid in full the charges for which I am requesting reimbursement and that I have not submitted these expenses to any other insurance, flexible spending account or other source for reimbursement.

_____ _____

Signature Date

Submit receipts/proof of payment to:

ASC
Metro IOD Program
P.O. Box 291587
Nashville, TN 37229-1587

Fax: 615-360-5692